Patient Information 2015

FATHER:

Name: (last) _____
(first) _____
Date of Birth: _____
Street Address: _____Apt:__
City: _____
State: _____ Zip: _____
Marital Status: _____
_
Home Phone: ( ) _____
_
Work Phone: ( ) _____
_
Cell Phone: ( ) _____
_
Social Security # _____
Employer: _____
Address: _____
City: _____ State:___ Zip____
Occupation: _____
Number of Dependents: _____
Insurance Company: _____
Address: _____
City: _____ State:___ Zip____
Insured's I.D. # _____
Group Name or # _____
_

MOTHER:

Name: (last) _____
(first) _____
_
Date of Birth: _____
Street Address: _____Apt: __
City: _____
State: _____ Zip: _____
Marital Status: _____
_
Home Phone: ( ) _____
_
Work Phone: ( ) _____
_
Cell Phone: ( ) _____
_
Social Security # _____
Employer: _____
Address: _____
City: _____ State:___ Zip____
Occupation: _____
Number of Dependents: _____
Insurance Company: _____
Address: _____
City: _____ State:___ Zip____
Insured's I.D. # _____
Group Name or # _____

CHILD (PATIENT): RACE/ETHNICITY (OPTIONAL): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Name: (last) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ (first) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ (M.I.) _ _ _

Date of Birth: _ _ _ _ _ _ _ _ _ _ _ _ Social Security # _ _ _ _ _ _ _ _ _ _ _ _ Sex (M/F) _ _ _ _

Street Address: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ City _ _ _ _ _ _ _ _ _ _ _ _ State _ _ _ _ _

Zip: _ _ _ _ _ _ _ Insurance: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ID # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Emergency Contact: _ Relationship: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Phone # _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Cell phone # _

Referred by: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

The patient is responsible for all fees unless covered by an insurance plan in which we participate. It is also customary to pay for our services when rendered unless other arrangements have been made with our billing department.

I hereby authorize Clarkstown Pediatrics to furnish information to insurance carriers concerning illness and treatments and I hereby assign to the physicians all payments for medical services rendered to my child/ children. I understand that I am responsible for any amount not covered by insurance. **I understand that I must call the office if I am unable to keep an appointment. This call needs to be made at least 24 hours prior to the appointment time. Otherwise Clarkstown Pediatrics will charge me a $25 fee.**

Date: _ _ _ _ _ _ _ _ _ _ _ _ Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

PARENT'S EMAIL ADDRESS:_____